MATRIXVIP

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Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(412) 586-4545**. We are here to assist you!

MENTAL HEALTH LONG-ACTING INJECTABLE ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: _____ **APPOINTMENT DATE (if known):** _____

FIRST NAME: _____ **LAST NAME:** _____

DOB: _____ ☐ **Female** ☐ **Male** **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURANCE COMPANY: _____ **ID#:** _____

GROUP#: _____ **EMERGENCY CONTACT:** _____

PRESCRIPTION INFORMATION

DIAGNOSIS: ☐ **F20.___(Schizophrenia)** ☐ **F25.___(Schizoaffective Disorder)** ☐ **F31.___(Bipolar Disorder)**

DRUG	STRENGTH				
☐ Abilify Maintena®	☐ 300mg	☐ 400mg			
☐ Aristada®	☐ 441mg	☐ 662mg	☐ 882mg	☐ 1064mg	
☐ Invega Sustenna®	☐ 39mg	☐ 78mg	☐ 117mg	☐ 156mg	☐ 234mg
☐ Invega Trinza®	☐ 273mg	☐ 410mg	☐ 546mg	☐ 819mg	
☐ Invega Hafyera®	☐ 1092mg	☐ 1560mg			
☐ Risperdal Consta®	☐ 12.5mg	☐ 25mg	☐ 37.5mg	☐ 50mg	
☐ Perseris®	☐ 90mg	☐ 120mg			
☐ _____	_____				

Directions: Administer 1 Injection IM every _____ ☐ **Weeks** ☐ **Month(s) Quantity:** _____ **Refills:** _____

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: _____ **ATTN:** _____

OFFICE ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

PRESCRIBER NAME _____

NPI: _____ **LICENSE:** _____ **DEA:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

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